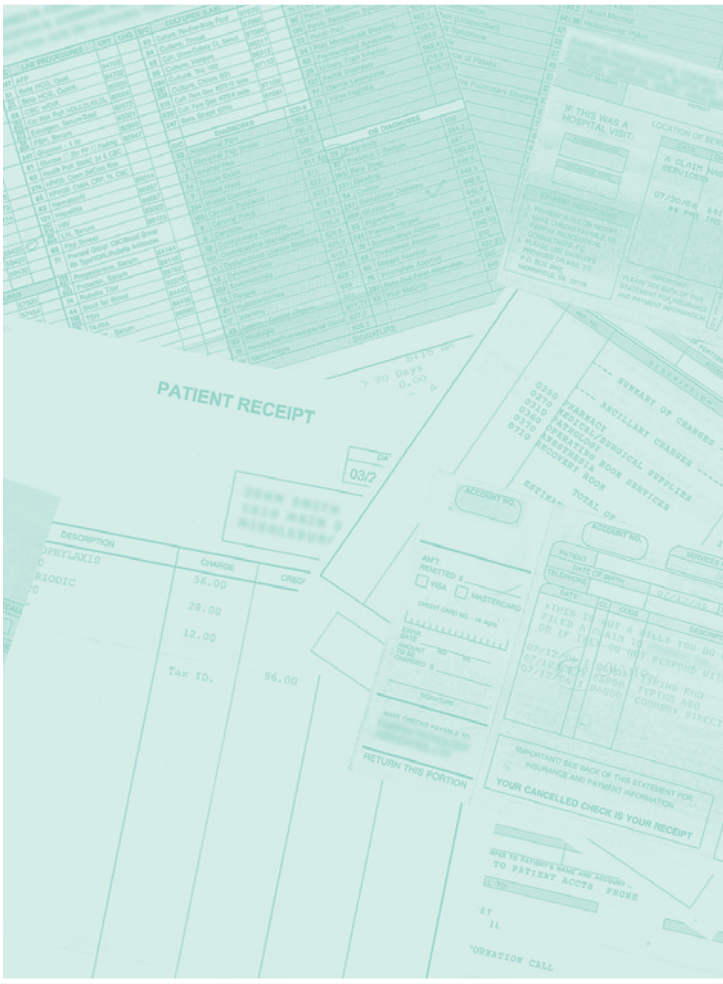
THE HENRY J. KAISER FAMILY FOUNDATION

# MATERNITY CARE AND CONSUMER-DRIVEN HEALTH PLANS

## EXECUTIVE SUMMARY




JUNE 2007

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# MATERNITY CARE AND CONSUMER-DRIVEN HEALTH PLANS


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# EXECUTIVE SUMMARY

## BACKGROUND

With approximately 4 million births in the United States each year,[1] pregnancy and childbirth-related conditions are the leading causes for hospital stays and account for almost 25 percent of U.S. hospitalizations.[2] The cost of having a baby can easily reach thousands of dollars, making insurance coverage critical for pregnant women. Predicting the cost of even a routine, planned pregnancy, however, can be difficult. Estimates of the cost of maternity-related care vary widely, as costs can be affected by many factors.

A family's out-of-pocket costs for maternity care depends on clinical factors as well as whether the woman has health insurance, the type of coverage, and how, if at all, her health insurance covers maternity care. With the development of a relatively new type of health insurance policy, consumer-driven health plans (CDHPs), the variation in costs that families face is likely to increase. Over the past few years, these policies have been marketed to individuals and employers as a more affordable insurance product that has lower premiums and may help to control health care costs.

Compared to traditional health plans, CDHPs have certain defining features, including more financial responsibility for patients for the cost of their medical care, particularly through higher deductible levels. Qualified CDHPs may be combined with tax-free savings accounts—Health Reimbursement Arrangements (HRAs) or Health Savings Accounts (HSAs)—to cover patients' out-of-pocket medical expenses. Contributions to these accounts can be made until the tax filing deadline for that year, even after health expenses have been incurred. The tax benefits from these accounts, combined with slightly lower premiums than traditional health plans and reductions in unnecessary health care utilization, are intended to make CDHPs lower in cost than more traditional plans.

To evaluate the level of insurance protection that CDHPs provide, this study examines CDHPs' coverage of maternity care, one of the most common and costly medical interventions that women of reproductive age will experience. This study discusses the costs of maternity care, the features of private health insurance affecting maternity coverage, and the issues raised by the development of CDHPs. Coverage, however, is only one part of the cost equation. Costs can vary dramatically depending on a patient's specific medical condition and pregnancy outcomes. Therefore, this analysis provides estimates of maternity care costs under three different clinical scenarios—an uncomplicated vaginal delivery, an uncomplicated Cesarean (C-section) delivery, and a pregnancy with considerable complications—and compares the level of coverage offered by one traditional insurer and 12 CDHPs in the group and individual markets.

## METHODS

Cost estimates for each of these scenarios were generated by compiling a list of medical services recommended for pregnancy related care and summing the average costs for these services from a sample of health plan claims. Services typically provided for prenatal care, vaginal delivery, C-section delivery, and gestational diabetes were based on professional practice guidelines developed by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP).[3] Researchers calculated median costs for these services using a sample of claims from 106 women covered under the Maryland Health Insurance Plan (MHIP), a state high-risk pool whose provider payment levels are thought to be consistent with those of other commercial insurers in Maryland.[4,5] These costs were then used to estimate total costs for the three clinical scenarios: 1) uncomplicated pregnancy and vaginal delivery, 2) uncomplicated C-section delivery, and 3) a complicated pregnancy with gestational diabetes, pre-term labor, and C-section delivery. In addition to clinical differences, these scenarios present some other different circumstances, such as pregnancy spanning over one or two plan years and anesthesia administered by an out-of-network provider, reflecting other dimensions of variability in pregnancies and the limited predictability of maternity care.

The features of 12 different types of CDHPs from the Federal Employees Health Benefits Program (FEHBP), the small group, and individual markets were compared to a policy that is more like "traditional" health insurance (Appendix 1). The cost estimates derived from the MHIP analysis were used to determine which costs were and were not covered by each of the plans and what share of total costs the insurance policy reimbursed (Appendices 2–4). Each insurance policy contract was analyzed to determine covered benefits for maternity care and related services and the level of coverage provided, including cost sharing requirements, under the three clinical scenarios.

## PLAN FEATURES

For the sake of brevity, the main body of the report presents a detailed analysis of four CDHPs as well as a traditional plan and their coverage for maternity care. Of the four CDHPs chosen, all cover maternity care and three are HSA-qualified. In plans that have HSAs, the enrolled person could use funds in an HSA to offset the costs that the plan did not reimburse. The major features of these five plans are summarized in Table A-1, and the characteristics for all 12 plans analyzed can be found in Appendix 1.

**TABLE A-1.**

## Key Features of Selected Consumer-Driven Health Plans that Cover Maternity Care

| | Traditional Plan | Consumer-Driven Health Plans | | | |
|---|---|---|---|---|---|
| **Plan Features** | **Plan A** | **Plan B** | **Plan H** | **Plan E** | **Plan K** |
| Market | FEHBP | FEHBP | Small Group | Small Group | Individual |
| HSA-qualified? | No | Yes | Yes | Yes | No |
| **Cost Sharing (In-Network)** | | | | | |
| Annual Deductible (individual/family) | $250/$500 | $1,500/$3,000 | $2,250/$4,500 | $3,500/$7,000 | $5,000/$10,000 |
| Co-insurance and Co-pays | 10% obstetric, hospital; 15% imaging, anesthesia, $0 for designated lab, $20 office visit (no deductible) | None for maternity care | 10% co-insurance | $35/office visit | 30% co-insurance |
| Annual OOP Maximum (individual/family) | $4,000 (per policy) | $4,000/$8,000 | $5,000/$10,000 | $4,000/$7,500 | $7,500/$15,000 |
| Includes Deductible? | No | Yes | Yes | Yes | Yes |
| Includes Co-pays? | No—n/a to prescription drugs | n/a | Yes | Yes | Yes |
| **Cost Sharing (Out-of-Network)** | | | | | |
| Annual Deductible (individual/family) | $300/$600 | Same as in-network | Same as in-network | $3,500/$7,000 | $5,000/$10,000 |
| Co-insurance and Co-pays | 30% co-insurance, $100 co-pay/ hospital admission + 30% co-insurance | 30% co-insurance | 30% co-insurance | 50% co-insurance (+ balance billing) | 50% co-insurance Hosp all amounts over $650/day |
| Annual OOP Maximum (individual/family) | $6,000 (per policy) | None | $10,000/$20,000 | $4,000/$7,500 | $7,500/$15,000 |
| Includes Deductible? | No | | Yes | Yes | Yes |

## KEY FINDINGS

Table A-2 compares the extent of coverage for the three scenarios under four of the CDHPs studied (Plans B, H, E, and K) to a traditional health insurance policy (Plan A). Scenario 1 aims to present a best-case scenario, with an uncomplicated pregnancy and uncomplicated vaginal delivery. In scenario 2, total costs increase primarily because of C-section delivery and a longer hospital stay as a result. Scenario 3 is the most expensive scenario due to pre-term labor and a long hospital stay during pregnancy. It is important to note that these scenarios are theoretical constructions designed to provide cost estimates to enable the comparison of potential out-of-pocket spending under different plans.

**Scenario 1:** It is assumed that the mother has family coverage when the pregnancy begins, the pregnancy begins and ends within a single plan year, and all care is received from in-network hospitals, doctors, and other providers. The uncomplicated pregnancy ends in vaginal delivery and the mother and baby stay in the hospital for two days. This pregnancy was estimated to result in $9,660 in allowable charges.

Under the traditional policy, out-of-pocket costs would total $1,455, or about 15 percent of allowed charges. For HSA-qualified CDHPs, out-of-pocket costs are higher because of their higher annual deductibles. The woman's cost liability can reach $3,000 to $7,000, or 31 percent to 73 percent of total allowed charges. In the case of the plan K, the individual plan that covered maternity care, the family was liable for $7,884 or 82 percent of costs.

**Scenario 2:** It is assumed that the mother has family coverage when pregnancy begins, and that her pregnancy spans two plan years, with routine prenatal care taking place under the first plan year but labor and delivery (C-section with three-day hospital stay) occurring the following year. The mother is assumed to seek all care within the plan network with the exception of anesthesia care during delivery (the anesthesiologist on call when she delivers is out-of-network) so balance billing costs may apply. Allowable charges for this pregnancy were estimated to be $12,453.

Under this scenario, family cost sharing increases somewhat due to balance billing by the out-of-network anesthesiologist. More significantly, family cost sharing increases under all plans because prenatal care in year one is subject to a separate annual deductible. First year costs to the family are somewhat lower under the traditional insurance policy because the mother's prenatal care is subject to the lower, embedded deductible for an individual. Under HSA-qualified CDHPs, however, the full family deductible must be satisfied in both years before claims are reimbursed. Family out-of-pocket expenses were $2,244 in the traditional policy and ranged from $3,545 to $9,818 in the CDHPs.

**Scenario 3:** In this scenario, it is assumed that the mother has family coverage at the outset of the pregnancy and her pregnancy spans two plan years, but this time medical complications arise. The mother develops gestational diabetes, which adds to her prenatal care costs. She also experiences pre-term labor and requires hospitalization during the first plan year. The pre-term labor hospitalization is assumed to cost $75,000. The baby is delivered by C-section just after the second plan year begins and requires several weeks in neonatal intensive care, assumed to cost another $200,000. All care is assumed to be received in-network under this scenario, and total allowed charges are $287,453.

Out-of-pocket costs are even higher under this scenario because maximum cost sharing limits are reached in two consecutive plan years. Under the traditional policy, the family's cost sharing exposure reaches $8,770, or about 3 percent of the total, catastrophic expense. The family's share of costs is lowest ($6,000) under one of the CDHPs, Plan B, because no cost sharing applies to maternity or other inpatient care after the deductible is met under this plan. By contrast, under CDHPs E, H, and K, the OOP maximums are much higher. Total spending for the family would be $14,000 to $21,194 under these plans, or 5 to 7 percent of total costs.

**TABLE A-2.**

## Out-of-Pocket Expenses for Maternity Care Under Three Different Scenarios

| | Insurer and Policy Features | | | | |
|---|---|---|---|---|---|
| | **Plan A Traditional Policy FEHBP** | **Plan B FEHBP CDHP** | **Plan H Small Group CDHP** | **Plan E Small Group CDHP** | **Plan K Individual Market CDHP** |
| **Plan Characteristics** | $250/$500 deductible; 10% co-insurance for obstetric, hospital; 15% imaging, anesthesia; nothing for preferred lab; $20 (no deduct) office; OOP $4,000 (per policy) only for co-insurance | $1,500/$3,000 deductible; no additional co-insurance for maternity; $4,000/ $8,000 OOP; HSA-qualified | $2,250/$4,500 deductible (in network); 10% co-insurance to OOP of $5,000/$10,000 (in network); HSA-qualified | $3,500/$7,000 deductible; no co-insurance; $4,000/$7,500 OOP; HSA-qualified | $5,000/$10,000; 30% co-insurance post-deductible until OOP max reached; OOP: $7,500/$15,000; not HSA-qualified |
| **Clinical Scenario and Estimated Total Cost** | **Family Out-of-Pocket Costs*** | | | | |
| **Scenario 1** Uncomplicated Pregnancy, Vaginal Delivery **$9,660** | **$1,455** (15%) | **$3,000** (31%) | **$5,016** (52%) | **$7,000** (73%) | **$7,884** (82%) |
| **Scenario 2** Uncomplicated Pregnancy, C-section Delivery **$12,453** | **$2,244** (18%) | **$3,545** (29%) | **$5,929** (48%) | **$7,688** (62%) | **$9,818** (79%) |
| **Scenario 3** Pregnancy with Gestational Diabetes, Pre-term Labor, C-section Delivery **$287,453** | **$8,770** (3%) | **$6,000** (2%) | **$20,000** (7%) | **$14,000** (5%) | **$21,194** (7%) |

*Families with tax-exempt HSA funds can apply account balances to these costs

## CONCLUSIONS

***Pregnant women could face exposure to high out-of-pocket costs under CDHPs, particularly when complications arise.***

While many CDHPs cover maternity care services, there is tremendous variation in the deductibles, cost sharing requirements, and out-of-pocket maximums between various CDHPs. This analysis finds that women and families could be left with thousands of dollars of expenses from maternity care even with an uncomplicated birth, resulting from the high deductibles and cost sharing requirements in these plans.

***Funds in an HSA may not be sufficient to cover the out-of-pocket costs resulting from pregnancy, particularly in the event of complications, leaving families with significant medical bills to pay. Even for families who had used their HSA to save for such an event, cost sharing for maternity care could drain an HSA, leaving little in reserve for other health care expenses.***

In this analysis, out-of-pocket costs for the best-case pregnancy scenario in CDHPs range from $3,000 to $7,000, which could take several years for a person to accumulate in an HSA. Previous research has found that about two-thirds of those with HSAs receive employer contributions to their accounts, and on average, employers contribute approximately $1,600, which falls short of maternity care cost liability under most of the plans analyzed. Furthermore, funds in an HSA may also be needed to pay for services not covered by the CDHP, such as dental, vision, or mental health care. The high costs of pregnancy alone could potentially exhaust a family's HSA, leaving little or no funds for other health care expenses.

***Prenatal care is generally subject to the deductible in CDHPs, unlike other preventive services, such as well-child care or mammography.***

CDHPs often exempt preventive services from the deductible or co-payments. In all of the plans that were examined, however, prenatal care services were not considered to be preventive services. High cost sharing could pose a disincentive for some women to obtain prenatal care services.

***Transparency remains a challenge, as health plan policies are complex, and the details of coverage are often not explicit.***

Transparency in health care costs is a cornerstone of the consumer-driven health care model, as it is expected that beneficiaries should have enough information to plan for health care expenses and set aside sufficient funds in an HSA to cover out-of-pocket costs. The details of a plan's coverage for specific services are not always apparent, making it very difficult to estimate spending accurately. Investigating the details of plan coverage for unpredictable health care needs, such as pregnancy complications, is even harder for consumers.

***Coverage for maternity care in the individual insurance market is extremely limited.***

Many plans in the nongroup market do not cover maternity care at all, and pregnancy can be grounds for denial of an application for coverage in medically underwritten policies. For CDHPs in the nongroup market that do cover maternity care though, out-of-pocket spending may be very high due to high deductibles and cost sharing as well as coverage exclusions for certain services.


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